DRIVER INFORMATION

NAME OF YOUR DRIVER _____ DATE OF BIRTH _____

CDL NO. _____ STATE _____

HOW LONG EMPLOYED AS YOUR DRIVER _____YEARS _____MONTHS

EXPIRATION DATE OF MEDICAL CERTIFICATE _____

FILL OUT THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF ACCIDENT.

AT TIME OF ACCIDENT, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD _____

TOTAL HOURS ON DUTY DURING THE PREVIOUS: (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)

7 CONSECUTIVE DAYS _____HOURS

8 CONSECUTIVE DAYS _____HOURS

CONDITION OF DRIVER (CIRCLE ONE): 1. NORMAL 2. HAD BEEN DRINKING

3. ILLEGAL DRUG USE 4. SICK 5. FATIGUE 6. DOZED AT WHEEL

7. OTHER _____

DOES YOUR DRIVER HAVE A MEDICAL WAIVER? ☐ YES ☐N

TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.): _____

DRIVER INJURY INFORMATION

YOUR DRIVER KILLED?	YOUR DRIVER INJURED?	RELIEF DRIVER KILLED?	RELIEF DRIVER INJURED?	TOTAL NO. PASSENGE
☐ YES ☐NO	☐ YES ☐NO	☐ YES ☐NO	☐ YES ☐NO	_____ KILLED _____INJURE

OTHER VEHICLE DRIVER INFORMATION

(VEH 2) DRIVER NAME	DRIVER LIC.#, STATE	YEAR, MAKE, TYPE OF VEHICLE (CAR, TRUCK, BIKE, MOTORCYCLE).	VEHICLE LIC. # STATE

(VEH 3) DRIVER NAME	DRIVER LIC.#, STATE	YEAR, MAKE, TYPE OF VEHICLE (CAR, TRUCK, BIKE, MOTORCYCLE)	VEHICLE LIC. # STATE

OTHER DRIVER INJURY INFORMATION

TOTAL NO. OF OTHER DRIVERS	TOTAL NO. OF OTHER PASSENGERS	TOTAL NO. OF PEDESTRIANS
_____ KILLED _____INJURED	_____ KILLED _____INJURED	_____ KILLED _____INJURED

ACCIDENT INFORMATION

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. **YOUR VEHICLE** IS ALWAYS **NO. 1.** IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 & 3 TO CORRESPON TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

VEHICLES			ACTION	VEHICLES			ACTION	VEHICLES			ACTION
1	2	3		1	2	3		1	2	3	
			SLOWING-STOPING				PASSING				JACKKNIFE
			STOPPED				CHANGING LANES				OVERTURN
			REAR-END				SIDESWIPE				SEPARATION OF UNITS
			BACKING				HEAD-ON				FIRE
			MAKING RIGHT TURN				SKIDDING				EXPLOSION
			MAKING LEFT TURN				VEH OUT OF CONTROL				CARGO SHIFT
			MAKING U-TURN				ROLL-AWAY				CARGO SPILL (HAZARDOUS)
			PROCEEDING STRAIGHT				CONTROLLED RR CROSSING				CARGO SPILL (NON-HAZARDOUS)
			INTERSECTION				UNCONTROLLED RR CROSSING				OTHER (DEER, GUARDRAIL, ETC.)
			ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)				RAN OFF ROAD				

DID YOUR VEHICLE STRIKE A PARKED VEHICLE? ☐ YES ☐NO

WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE? ☐ YES ☐

DESCRIPTION OF ACCIDENT BY CARRIER OFFICIAL: _____

TOTAL DAMAGES TO ALL VEHICLES AND PROPERTY: $ _____

TOTAL DAMAGES TO YOUR VEHICLE AND PROPERTY: $ _____

NAME AND TITLE OF PERSON SIGNING REPORT

TELEPHONE NO. ( )

SIGNATURE

DATE